MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7849

CERTIFICATE OF DEATH

Reg. Dist. No. 07818

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bay View
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bay View NORTH EAST RURAL
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernest — Middle: B — Last: Abrams

4. DATE OF DEATH: Month: July — Day: 17 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 7, 1874

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bricklayer, ret.

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Abrams

14. MOTHER'S MAIDEN NAME: Talitha Janney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 213-12-2741

17. INFORMANT — Address: Miss Audrey M Abrams, Bay View, Ma ryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 20, 19 59, to July 17, 19 59, that I last saw the deceased alive on July 16, 19 59, and that death occurred at 4 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews Jr. M.D.
ADDRESS (Street, city or town, state): 233 E. Main Street
DATE SIGNED: 7/17/59

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. — Elkton — Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-19-59
22c. NAME OF CEMETERY OR CREMATORY: Bay View Meth. Cem.
22d. LOCATION (City, town, or county): Bay View (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Hurst
ADDRESS: North East, Maryland

24a. REC'D BY REGISTRAR — DATE: JUL 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kime

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7833 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07819

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	DAVID	JOSEPH	BRENNAN		July	22,	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		MAY 30 1894	65 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	GENERAL	PENNA.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
THOMAS BRENNAN	NO INFO.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	WW I	716-05-3560	JOSEPH N. BRENNAN	ELKTON, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Drowning	
929.8 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Found drowned

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
4:25 p. m.	July 22, 1959		Creek	Elkton	Cecil	Maryland

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: William V. Lovitt, Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 7/23/59

EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	7/25/59	ELKTON CEMETERY	ELKTON, Md

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
PIPPIN FUNERAL HOME	ELKTON, Md.	JUL 28 '59	Arthur L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7850

CERTIFICATE OF DEATH

Reg. Dist. No. 17820

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL — CONOWINGO
c. LENGTH OF STAY IN 1b: 25 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: X

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL — CONOWINGO
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EVA — Middle JANE — Last BROWN

4. DATE OF DEATH: Month JULY — Day 1 — Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/29/1900
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TAVERN KEEPER
10b. KIND OF BUSINESS OR INDUSTRY: TAVERN
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM MILLER
14. MOTHER'S MAIDEN NAME: CLARA SHENK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-20-8404
INFORMANT: CLIFTON BROWN — Address: CONOWINGO, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro vascular accident — INTERVAL BETWEEN ONSET AND DEATH: one hour
331 X
DUE TO (b): Arteriosclerosis — 5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4 ____, 19 53, to 7/1 ____, 19 59, that I last saw the deceased alive on 7/1 ____, 19 59, and that death occurred at 3 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md — DATE SIGNED: 7/1/59
PHYSICIAN'S NAME (Type): Neil Taylor — Rising Sun, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7/4/1959
22c. NAME OF CEMETERY OR CREMATORY: HOPEWELL
22d. LOCATION (City, town, or county) (State): PORT DEPOSIT, MD

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ralph M Reed, Rising Sun, Md
24a. REC'D BY REGISTRAR DATE: JUL 6 '59
24b. REGISTRAR'S SIGNATURE: Evelyn S. Hanson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7851

CERTIFICATE OF DEATH

07821

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 1 mo. 6 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. STREET ADDRESS: 935 - 48th Place, N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

3. NAME OF DECEASED (Type or print): First SAMUEL — Middle F. — Last BROWN

4. DATE OF DEATH: Month July — Day 31 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ (Sep) NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-28-93

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator

10b. KIND OF BUSINESS OR INDUSTRY: Elevator

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James H. Brown - Deceased

14. MOTHER'S MAIDEN NAME: Mary (?) Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 125-038-743

INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonis bilateral unresolved — INTERVAL BETWEEN ONSET AND DEATH: 3-5 days
203X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Plasma cell myeloma — unknown
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 VA

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 25, 1959, to July 31, 1959 and that death occurred at 12:29 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. L. Garey M.D.
ADDRESS (Street, city or town, state): V.A.Hospital, Perry Point, Md.
DATE SIGNED: 8-5-59

PHYSICIAN'S NAME (Type): J. L. GAREY
Clinical Pathologist

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 8/6/1959
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son
ADDRESS: Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE: AUG 7 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7852

CERTIFICATE OF DEATH

07822

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 2yrs.4mo.28days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ohio
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Route #2 Willoughby 72 x 3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M
I
050

3. NAME OF DECEASED (Type or print): First ALBIN — Middle K. — Last BUHLER

4. DATE OF DEATH: Month July — Day 10 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-20-02

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lewis Buhler - Deceased

14. MOTHER'S MAIDEN NAME: Annie Barstow - Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: Not obtainable

INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 3 to 4 days
421.4
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b) Chronic valvular heart disease of unknown
DUE TO
(c) unknown etiology — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from February 12, 1957, to July 10, 1959, that I last saw the deceased [illegible], and that death accurred at 6:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. S. Ells, M.D.
ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.
DATE SIGNED: 7-10-59

PHYSICIAN'S NAME (Type): E.S. ELLS, M.D., ACTING DIRECTOR, PROFESSIONAL SERVICES.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 7/13/59
22c. NAME OF CEMETERY OR CREMATORY: South Kirtland
22d. LOCATION (City, town, or county) (State): Willoughby, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son
ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: JUL 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07823

7853

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 29yrs.10mo.24days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Halifax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): South Boston 83x-3
d. STREET ADDRESS: 1010-3rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

550

3. NAME OF DECEASED (Type or print): First ALFRED — Middle M. — Last CHILDRESS

4. DATE OF DEATH: Month July — Day 20 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-15-97

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator

10b. KIND OF BUSINESS OR INDUSTRY: Telegraph

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Winthrop H. Childress

14. MOTHER'S MAIDEN NAME: Mattie Lee Hemrey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: Not obtainable

INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia bilateral unresolved — INTERVAL BETWEEN ONSET AND DEATH: 6-7 days

430.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Sub-acute bacterial endocarditis, organism — unknown

DUE TO (c): Aortic valve, vegetations of unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, generalized, moderately severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from August 26, 19 29, to July 20, 1959 and that death occurred at 12:01 am from the causes and an the date stated abave.

ADDRESS (Street, city or town, state) — DATE SIGNED

ACTUAL SIGNATURE: J. L. Garey M.D. — V.A.Hospital, Perry Point,Md. — 7-20-59

PHYSICIAN'S NAME (Type): J. L. GAREY — Clinical Pathologist

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 20

22c. NAME OF CEMETERY OR CREMATORY: Oak Ridge Cemetery

22d. LOCATION (City, town, or county) (State): South Boston Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Powell Funeral Home — ADDRESS: Powell Funeral Home, South Boston, Virginia

24a. REC'D BY REGISTRAR DATE: JUL 29 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 117824

7854 CERTIFICATE OF DEATH Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD Middle J. Last CONWAY

4. DATE OF DEATH: Month July Day 31 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 4, 1898

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Conway

14. MOTHER'S MAIDEN NAME: Sarah Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-II

16. SOCIAL SECURITY NO.: Unknown

INFORMANT Address: Hospital Records, VA Hosp., Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral, unresolved. — INTERVAL BETWEEN ONSET AND DEATH: 48-72 hrs.

104.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Rocky mountain spotted fever (Clinical) — Unknown
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma, squamous cell type, of oropharnyx.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year: VA 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 27, 1959, to July 31, 1959 [redacted] and that death occurred at 11:50AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. L. Garey M.D.
ADDRESS (Street, city or town, state): Perry Point, Md.
DATE SIGNED: 8-1-59

PHYSICIAN'S NAME (Type): J. L. GAREY, M.D.
V.A. Hospital, Perry Point, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-3-1959
22c. NAME OF CEMETERY OR CREMATORY: Bethel
22d. LOCATION (City, town, or county) (State): Chesapeake City Cecil Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant
ADDRESS: North East Md

24a. REC'D BY REGISTRAR DATE: AUG 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7834

CERTIFICATE OF DEATH

Reg. Dist. No. 07825

1. PLACE OF DEATH
a. COUNTY Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton Md
c. LENGTH OF STAY IN 1b 1 Week
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rising Sun
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Anna Middle Mary Last Crothers

4. DATE OF DEATH Month July Day 2 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct. 1, 1874
9. AGE (In years last birthday) 84 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress Maker
10b. KIND OF BUSINESS OR INDUSTRY In own Home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Crothers
14. MOTHER'S MAIDEN NAME Hannah Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Florence England Address Rising Sun, Md. R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized arteriosclerosis,
DUE TO (b) Cardio-renal disease
DUE TO (c) and cerebral accident

INTERVAL BETWEEN ONSET AND DEATH
(a) (b) (c) May 31-1959

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 31, 1959, to June 2, 1959, that I last saw the deceased alive on June 2, 1959, and that death occurred at 11:15 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE Richard H. Speaks, M.D. ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED June 2-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7-5-1959
22c. NAME OF CEMETERY OR CREMATORY Rosebank Cem.
22d. LOCATION (City, town, or county) Calvert (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Herman E. Mueller ADDRESS Rising Sun Md
24a. REC'D BY REGISTRAR DATE JUL 7 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7835 **CERTIFICATE OF DEATH** Reg. Dist. No. 07826

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Devine Haven Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton R.D.# 4
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Fred — Middle Cathers — Last Ewing

4. DATE OF DEATH: Month July — Day 21 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 8, 1877

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mfg.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David N. Ewing

14. MOTHER'S MAIDEN NAME: Mary A. Holland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-05-3471

17. INFORMANT Address: Mrs. Emma Ewing, Elkton, Md. R.D.#4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Heart Failure	1 day
DUE TO (b)	AMI	5 days
DUE TO (c)	Coronary Arteriosclerosis	10 Years

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive encephalopathy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 59, to 7-21, 19 59, that I last saw the deceased alive on 7-21, 19 59, and that death occurred at 10:24 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter Stavrakis, M.D. — ADDRESS (Street, city or town, state): 154 N. Main — DATE SIGNED: 7-21-59

PHYSICIAN'S NAME (Type): PETER STAVRAKIS M.D. ELKTON Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/24/59

22c. NAME OF CEMETERY OR CREMATORY: Sharps Cemetery

22d. LOCATION (City, town, or county) (State): Fair Hill, Cecil, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hess — ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE JUL 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7855 Items 8,9 FilmG245 7-29-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 96 07827

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. STREET ADDRESS: 2313 - 36th Street, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CLYDE	M.	FRYER	July	16	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		5-6-96 1892	67 63 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Book Binder	U.S.Government	Pennsylvania	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John B. Fryer - Deceased	Miranda Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
Yes — WW I	None	Hospital Records, VAH, Perry Point, Md.

1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved — INTERVAL BETWEEN ONSET AND DEATH: 3-5 days

162.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: Bronchogenic carcinoma right lung with wide-spread metastases to the left lung, bone, lymph nodes and liver — unknown

(c)

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, generalized, severe - unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 8, 1959, to July 16, 1959 ~~that I last saw the deceased~~ and that death occurred at 6:45a M, from the causes and on the date stated above.

VA

ACTUAL SIGNATURE: J. L. Garey M.D. — ADDRESS (Street, city or town, state): V.A.Hospital, Perry Point, Md. — DATE SIGNED: 7-16-59

PHYSICIAN'S NAME (Type): J. L. GAREY — Clinical Pathologist

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7/19/59	Circle Hill Cem.	Punxsutawney Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
J.William Lee, 4th St.&Mass.Ave.N.E,Wash.D.C.	JUL 20 '59	Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7836 **CERTIFICATE OF DEATH** 07828

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS: 325 North Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OLIVER Middle: C, Last: Giles, Jr.

4. DATE OF DEATH: Month: 7 Day: 26 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 20, 1903

9. AGE (In years last birthday): 56 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retail Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Grocer

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oliver C. Giles, Sr.

14. MOTHER'S MAIDEN NAME: Idella (UNknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Eulah Johnson Giles, Elkton, Md. Address: 325 North St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Post-operative Thigh Amputation — 6 days
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIAbeTes mell.Tus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/20, 19 59, to 7/26, 19 59, that I last saw the deceased alive on 7/26, 19 59, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John A Fischer M.D. — ADDRESS (Street, city or town, state): 162 W. MAIN ST. — DATE SIGNED: 7/26/59

PHYSICIAN'S NAME (Type): John A. Fischer — ELKTON, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/29/59

22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

22d. LOCATION (City, town, or county) (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: AUG 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7837

CERTIFICATE OF DEATH

07829
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elkton
d. STREET ADDRESS: R D # 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Karen — Middle: L V N — Last: Hall

4. DATE OF DEATH: Month: July — Day: 10 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 10th 1959

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 4 — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Elkton Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James M. Hall

14. MOTHER'S MAIDEN NAME: Dolores Tannard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: James M. Hall — Address: —

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Dosis - intestinis — INTERVAL BETWEEN ONSET AND DEATH: 18 hours
DUE TO
(b): Syndrome —
DUE TO
(c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

571.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 9, 1959 to July 10, 1959, that I last saw the deceased alive on July 10, 1959, and that death occurred at 4:50 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Mc Ford H Speaks M.D. — ADDRESS (Street, city or town, state): Elkton Md — DATE SIGNED: July 11-59

PHYSICIAN'S NAME (Type): —

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 7/12/59 — 22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery — 22d. LOCATION (City, town, or county): Elkton (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: H. Walter Du Bois — ADDRESS: Elkton Md

24a. REC'D BY REGISTRAR DATE: JUL 14 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Kruse

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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2265202 XV3

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7856 Items 2,3,13,17 FilmG245 7-2-59 et

07830

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Earville R.D.
   c. LENGTH OF STAY IN 1b: Visiting
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Pa. — b. COUNTY: Montomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Merenezzeds Wynnewood Wynnewood 75 X 3
   d. STREET ADDRESS: Moreno Road.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: Lawrence — Last: Higgins

4. DATE OF DEATH: Month: 7 — Day: 11 — Year: 19 59

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-21-1896

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Mang.

10b. KIND OF BUSINESS OR INDUSTRY: Yale &Towne

11. BIRTHPLACE (State or foreign country): St. Paul. Minn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Higgins

14. MOTHER'S MAIDEN NAME: Dorthy Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No. 1 None

16. SOCIAL SECURITY NO.: 162-01-5782

17. INFORMANT: Darthea Higgins — Address: Mrs. Dorthea Giggin, Moreno RD. WynwoodPa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C.Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 7-11-59

EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 7-12-59

22c. NAME OF CEMETERY OR CREMATORY: Annapolis Memorial Gar.

22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edward F. Gilbert — ADDRESS: Millington Md

24a. REC'D BY REGISTRAR: DATE JUL 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krug

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7857

CERTIFICATE OF DEATH

07831

Reg. Dist. No. 97

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bainbridge
c. LENGTH OF STAY IN 1b: 8 hr. 30 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Naval Hospital, Bainbridge, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bainbridge
d. STREET ADDRESS: Trailer 19, Bainbridge Village
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Manuel — Middle: Ricardo — Last: House

4. DATE OF DEATH: Month: July — Day: 4 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negroid

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4 July 1959

9. AGE (In years last birthday): -- yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: 8 — Min.: 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: William Warren House

14. MOTHER'S MAIDEN NAME: Patricia Hilliard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: --

17. INFORMANT — Address: Hospital Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PREMATURITY
776 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 8 hr. 30 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4 July, 1959, to 4 July, 1959, that I last saw the deceased alive on 4 July, 1959, and that death occurred at 7:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Victor E. Cornett M.D.

ADDRESS (Street, city or town, state): U. S. Naval Hospital, Bainbridge, Md.

DATE SIGNED: 4 July 59

PHYSICIAN'S NAME (Type): Victor E. Cornett, LT MC USNR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-6-1959

22c. NAME OF CEMETERY OR CREMATORY: Cobeesburg Cem.

22d. LOCATION (City, town, or county) (State): Port Deposit Md Rural

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Lewis Patterson & Sons, Perryville, Md

24a. REC'D BY REGISTRAR DATE: JUL 7 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

2051172 XVO

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7838

CERTIFICATE OF DEATH

Reg. Dist. No. 07832

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Devine Haven Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS: 109 Church Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie; Middle: P.; Last: Hudson

4. DATE OF DEATH: Month: July; Day: 22,; Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 21, 1882

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Lusby

14. MOTHER'S MAIDEN NAME: Mary Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Charles Q. Hudson, 109 Church St. Elkton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 3, 19 59 to July 22, 19 59, that I last saw the deceased alive on July 22, 19 59, and that death occurred at 9:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews Jr. M.D. — ADDRESS (Street, city or town, state): 233 E. Main St. — DATE SIGNED: 7/22/59

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. — Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/25/59

22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery

22d. LOCATION (City, town, or county) (State): Bethel, Cecil Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: JUL 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7839

Reg. Dist. No. 07833

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Elkton
d. STREET ADDRESS: R.D #4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Clinton Middle: Mitchell Last: Jaquette, Sr.

4. DATE OF DEATH: Month: July Day: 14 Year: 19 59

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 26, 1882

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Jaquette

14. MOTHER'S MAIDEN NAME: Martha Bristow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Clinton Jaquette, Jr. Address: Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO (b): renal disease
DUE TO (c):

442 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 23, 1959, to July 14, 1959, that I last saw the deceased alive on July 11, 1959, and that death occurred at 2:15a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr. M.D.
ADDRESS (Street, city or town, state): 233 E. Main Stree t
DATE SIGNED: July 15, 1959

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. Elkton Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/16/59
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cem.
22d. LOCATION (City, town, or county) (State): Bethel Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Walter Lee Boone Jr.
ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: JUL 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7840

Reg. Dist. No. 07834

1. PLACE OF DEATH
o. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 13 Yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 2 Norman Allen

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS: 2 Norman Allen
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRIEDA — Middle BUNTING — Last KASISKY

4. DATE OF DEATH: Month July — Day 1, — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 14, 1903
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: W. Maurice Bunting
14. MOTHER'S MAIDEN NAME: Sara Wentz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 141-14-3322
17. INFORMANT: George J. Kasisky — Address: Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT LUNG — INTERVAL BETWEEN ONSET AND DEATH: 10 MONTHS
163x
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1958, to July 1, 1959, that I last saw the deceased alive on June 30, 1959, and that death occurred at 11:35 P.M., from the causes and an the date stated above.

ACTUAL SIGNATURE: Ken Davis, M.D. — ADDRESS (Street, city or town, state): Chesapeake City Md — DATE SIGNED: July 1-1959

PHYSICIAN'S NAME (Type): HENRY V. DAVIS M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/4/59
22c. NAME OF CEMETERY OR CREMATORY: Immaculate Conception
22d. LOCATION (City, town, or county) (State): Nr. Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME — ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: JUL 6 '59
24b. REGISTRAR'S SIGNATURE: Clinton S. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG244 7-20-59 et

7841

CERTIFICATE OF DEATH

Reg. Dist. No. 07835

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 8 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East R.D.2
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

065

3. NAME OF DECEASED (Type or print): First Bertha; Middle H.; Last Levredge

4. DATE OF DEATH: Month July; Day 12; Year 59 19

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 9, 1890

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---6---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Pryor

14. MOTHER'S MAIDEN NAME: Tyson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Clarence J. Levredge — Address: North East R.D.2 Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Adenocarcinoma — INTERVAL BETWEEN ONSET AND DEATH: 2 years.

151X

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Adenocarcinoma of Stomach — 3 years

DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 July, 19 59, to 12 July, 19 59, that I last saw the deceased alive on 12 July, 19 59, and that death occurred at 2 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D. — ADDRESS (Street, city or town, state): North East Md — DATE SIGNED: 12 July '59

PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 15, 1959

22c. NAME OF CEMETERY OR CREMATORY: Methodist, Harts

22d. LOCATION (City, town, or county) (State): North East R.D.2, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant — ADDRESS: North East, Maryland

24a. REC'D BY REGISTRAR DATE: JUL 15 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7842

CERTIFICATE OF DEATH

Reg. Dist. No. 117836

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 5 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Devine Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS: 403 Park Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Gertrude Middle H. Last McAllister

4. DATE OF DEATH: Month July Day 24 Year 1959

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 8. DATE OF BIRTH: June 8 1873 — 9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: House work
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Andrew W. Holt
14. MOTHER'S MAIDEN NAME: Anna J Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Holt McAllister — Address: Elkton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Cardio-Vascular-Renal — 1954
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__, to July 24, 1959 that I last saw the deceased alive on July 22, 1959, and that death occurred at 4:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 135 W. Main, Elkton Md — DATE SIGNED: July 24

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/27/59
22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
22d. LOCATION (City, town, or county) (State): Elkton Md.

23. FUNERAL DIRECTOR'S SIGNATURE: N. Walter DuBoz Jr. — ADDRESS: Elkton
24a. REC'D BY REGISTRAR DATE: JUL 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7843

CERTIFICATE OF DEATH

Reg. Dist. No. 07837

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 13 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: DEVINE HAVEN NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ELKTON RD # 1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First BONNIE — Middle HAMILTON — Last McKEE

4. DATE OF DEATH: Month JULY — Day 21, — Year 19 59

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 2, 1878
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR — Months / Days; IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): TEXAS
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANK HAMILTON
14. MOTHER'S MAIDEN NAME: JENNIE BREWER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: SARA M COOKE — Address: ELKTON, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARCINOMA OF VULVA — INTERVAL BETWEEN ONSET AND DEATH: 3 YRS.
176.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 1, 19 55, to July 21, 19 59, that I last saw the deceased alive on July 21, 19 59, and that death occurred at 11:50 M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry Davis M.D. — ADDRESS (Street, city or town, state): Chesapeake Ave — DATE SIGNED: 7/22/59

PHYSICIAN'S NAME (Type): HENRY DAVIS M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
22b. DATE THEREOF: 7/22/59
22c. NAME OF CEMETERY OR CREMATORY: SILVER BROOK
22d. LOCATION (City, town, or county) (State): WILM, DEL.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME — ADDRESS: Donald M. Pippin ELKTON Md.

24a. REC'D BY REGISTRAR DATE: JUL 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7,8,9 FilmG244 7-20-59 et

7844

CERTIFICATE OF DEATH

Reg. Dist. No. 07838

1. PLACE OF DEATH
a. COUNTY Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Clara Middle Last McMullen
4. DATE OF DEATH Month July Day 10 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Oct 5 1871
9. AGE (In years last birthday) 87 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Rising Sun Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Keyser
14. MOTHER'S MAIDEN NAME Susan Connelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Harry C McMullen Rising Sun Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 24 hours
DUE TO (b) Cerebral Arteriosclerosis — 7 yeas
DUE TO (c)
332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9 July, 1959, to 10 July, 1959, that I last saw the deceased alive on 9 July 1959, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE wallace Oberlain M.D. ADDRESS (Street, city or town, state) Cecilton, Md DATE SIGNED 10 July 59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7/11/59
22c. NAME OF CEMETERY OR CREMATORY Friends Cem.
22d. LOCATION (City, town, or county) Colora (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph M Reed, Rising Sun Md
24a. REC'D BY REGISTRAR DATE JUL 14 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7845

CERTIFICATE OF DEATH

Reg. Dist. No. 07839

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON Cecilton
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harrisburg 75 x-3
d. STREET ADDRESS: Greyco Apts. North St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Sterling Middle G. Last McNees

4. DATE OF DEATH: Month July Day 15 Year 1959

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 17, 1887
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney
10b. KIND OF BUSINESS OR INDUSTRY: Law
11. BIRTHPLACE (State or foreign country): Gritty, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Geord McNees
14. MOTHER'S MAIDEN NAME: Anna George.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 169-201-714
17. INFORMANT: Address: Sterling McNees 33 Sprondell Rd Lang Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive cerebro-vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
331x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Arteriosclerosis — year.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 12, 1959, to July 15, 1959, that I last saw the deceased alive on July 15, 1959, and that death occurred at 9:15 a.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Openshain M.D. ADDRESS (Street, city or town, state): CECILTON, Md DATE SIGNED: 15 July 59

PHYSICIAN'S NAME (Type): WALLACE OPENSHAW

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 7/15/59
22c. NAME OF CEMETERY OR CREMATORY: HARRISBURG,
22d. LOCATION (City, town, or county) (State): PENNA.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME ADDRESS: ELKTON Md
24a. REC'D BY REGISTRAR DATE: JUL 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7846 — Reg. Dist. No. — 07840

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 4 HRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CHARLESTOWN
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EVELYN — Middle FRANCIS MEREDITH — Last
4. DATE OF DEATH: Month JULY — Day 28 — Year 1959

5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 23, 1884
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JAMES TAYLOR
14. MOTHER'S MAIDEN NAME: NO INFO.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS. MARSHALL MOORE — Address: CHARLESTOWN Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA of STOMACH — INTERVAL BETWEEN ONSET AND DEATH: yr.
DUE TO
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive Cardiovascular Renal Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 July, 1959, to 28 July, 1959, that I last saw the deceased alive on 28 July, 1959, and that death occurred at 6:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D. — ADDRESS (Street, city or town, state): North East, Md. — DATE SIGNED: 28 July '59
PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7/31/59
22c. NAME OF CEMETERY OR CREMATORY: LAWN CROFT CEMETERY
22d. LOCATION (City, town, or county) (State): CHESTER, PA.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME — ADDRESS: ELKTON, Md.

24a. REC'D BY REGISTRAR DATE: JUL 31 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7858

CERTIFICATE OF DEATH

Reg. Dist. No. 07841

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Elkton
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Emma — Middle Louisa — Last Moore

4. DATE OF DEATH: Month 7 — Day 19 — Year 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: May 29 1869

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Torbert Scarborough

14. MOTHER'S MAIDEN NAME: Wilhemina Campbell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Louise Moore — Address: Elkton R.D.4 Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial failure	3 days
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	arteriosclerosis of coronary arteries	15 yrs
(c)	arteriosclerosis generalized.	20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 2, 19 47, to July 19, 19 59, that I last saw the deceased alive on July 18, 19 59, and that death occurred at 1:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace M. Johnson M.D. — ADDRESS (Street, city or town, state): 257 E. Main St — DATE SIGNED: 7/21/59

PHYSICIAN'S NAME (Type): Wallace M. Johnson M.D. — Newark, Delaware

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-22-1959

22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Methodist

22d. LOCATION (City, town, or county) (State): Elkton R.D. Cecil Co., Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph F. Grant — ADDRESS: ~~North East~~, Maryland

24a. REC'D BY REGISTRAR DATE: JUL 23 '59

24b. REGISTRAR'S SIGNATURE: Carlton L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7859 **CERTIFICATE OF DEATH** Reg. Dist. No. 07842

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Elm St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS: Elm St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mabel — Middle V. — Last Noel
4. DATE OF DEATH: Month July — Day 5 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 3, 1908
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Millard Kirby
14. MOTHER'S MAIDEN NAME: Mabel Holland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.:
INFORMANT Address: John F. Noel, Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE CORONARY Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: IMMED
420.1
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1959, to July 5, 1959, that I last saw the deceased alive on June 29, 1959, and that death occurred at 1030P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dudley Phillips Jr M.D. — ADDRESS (Street, city or town, state): DARLINGTON Md — DATE SIGNED: 7/7/59

PHYSICIAN'S NAME (Type): Dudley Phillips M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-8-1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. Erin Cemetery
22d. LOCATION (City, town, or county) (State): Havre De Grace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lewis Patterson & Sons, — ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: JUL 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7860 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 96 07843

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 8 mo. 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1313 Linden Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NOEL — Middle B. — Last SAMUELS

4. DATE OF DEATH: Month July — Day 14 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/2/20

9. AGE (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Not obtainable

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Montague Samuels

14. MOTHER'S MAIDEN NAME: Nora Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 218-12-4071

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bilateral intraventricular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

331X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Blacked out and fell.

20c. TIME OF INJURY — Hour — o. m. / p. m. — Month, Day, Year: 7-12 59

20d. INJURY OCCURRED — While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Baltimore Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒? Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R C Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 7-14-59

EXAMINER'S NAME (Type): R. C. DODSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-16-59

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son

ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR — DATE: JUL 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7861

CERTIFICATE OF DEATH

Reg. Dist. No. 07844 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 8 mo. 23 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsburgh 75 X-3
d. STREET ADDRESS: 120 Hemlook
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First SCHOHE — Middle EDWARD — Last H.

4. DATE OF DEATH: Month July — Day 20 — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 2-23-92
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman
10b. KIND OF BUSINESS OR INDUSTRY: Not obtainable
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Valentine Schohe
14. MOTHER'S MAIDEN NAME: Minnie Brumer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: Not obtainable
INFORMANT: Hospital Records, VAH, Perry Point, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia bilateral unresolved — INTERVAL BETWEEN ONSET AND DEATH: 5-6 days
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease — unknown
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 27, 1958, to July 20, 1959, that I last saw the deceased alive on [illegible], and that death occurred at 12:00 Noon, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. L. Garey M.D.
ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.
DATE SIGNED: 7-22-59
PHYSICIAN'S NAME (Type): J. L. GAREY
Clinical Pathologist

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 7/23/59
22c. NAME OF CEMETERY OR CREMATORY: Uniondale
22d. LOCATION (City, town, or county) (State): Pittsburgh, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son
ADDRESS: Havre de Graoe, Md.
24a. REC'D BY REGISTRAR DATE: JUL 27 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Hance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7847

CERTIFICATE OF DEATH

Reg. Dist. No. 07845

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): X North East Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Karen — Middle — Last Sinclair

4. DATE OF DEATH: Month July — Day 30 — Year 1959

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-29-1959
9. AGE (In years lost birthday) yrs.:
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 6 — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (Stote or foreign country): Elkton
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Meade Sinclair
14. MOTHER'S MAIDEN NAME: Shirley Gatchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Mrs Shirley Gatchell — Address: North East Rd, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Septicemia (?) — INTERVAL BETWEEN ONSET AND DEATH: (a hours)
761.5
DUE TO (b): Amniotis (?) — 7wks
Conditions, if ony, which gave rise to immediote cause (o), stoting the underlying cause last.
DUE TO (c): Premature Rupture of Membranes and Premature by 32 wk. gestation - weight 4 lbs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year —— 19
20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐
20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that I attended the deceased from 29 July, 1959, to 30 July, 1959, that I last saw the deceased alive on 30 July, 1959, and that death occurred at 4:40 A.M., from the causes and on the date stated abave.

ACTUAL SIGNATURE: Hlaus H. Huebner M.D. — ADDRESS (Street, city or town, stote): North East Md — DATE SIGNED: 30 July '59

PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-30-1959
22c. NAME OF CEMETERY OR CREMATORY: North East Methodist
22d. LOCATION (City, town, or county) (Stote): North East Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant — ADDRESS: North East, Maryland
24a. REC'D BY REGISTRAR DATE: JUL 31 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2065 221XV2

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7848

CERTIFICATE OF DEATH

Reg. Dist. No. 07846

065

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 9 weeks
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Union

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East — Rural
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alta — Middle: Virginia — Last: Slayman

4. DATE OF DEATH: Month: July — Day: 8 — Year: 19 59

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 19, 1908

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Boggs

14. MOTHER'S MAIDEN NAME: Leah Hubbard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 215-24-0812

17. INFORMANT: Stanley Slayman — Address: North East, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 4 months

241X

Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (b): Allergic Bronchial Asthma — 10yrs +

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) — (County) — (State)

21. I certify that I attended the deceased from 10 May, 19 59, to 8 July, 19 59, that I last saw the deceased alive on 8 July, 19 59, and that death occurred at 12:30 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D. — ADDRESS (Street, city or town, state): North East, Md — DATE SIGNED: 8 July '59

PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-11-1959

22c. NAME OF CEMETERY OR CREMATORY: Baker

22d. LOCATION (City, town, or county) (State): Pound, Wise County, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Joseph R. Grant, North East, Maryland

24a. REC'D BY REGISTRAR DATE: JUL 10 '59

24b. REGISTRAR'S SIGNATURE: Curtis L. Kent

Housewife

Henry Boggs

no 215-24-0812 Stanley Slayman North East, Maryland

Leah Hubbard

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7862

CERTIFICATE OF DEATH

07847

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 1 mo. 16 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 110 Grant
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

12-31-2

050

3. NAME OF DECEASED (Type or print): First JAMES — Middle (NMI) — Last WALKER

4. DATE OF DEATH: Month July — Day 24 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 25, 1896

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meat Inspector

10b. KIND OF BUSINESS OR INDUSTRY: Dept. of Agriculture

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Walker (Deceased)

14. MOTHER'S MAIDEN NAME: Elizabeth Rostron (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: None

INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the lungs with metastasis
163X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from June 8, 1959, to July 24, 1959 and that death occurred at 11:55 am from the couses ond on the dote stated above.

ACTUAL SIGNATURE: J. R. Garcia Velez M.D.

ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.

DATE SIGNED: 7-24-59

PHYSICIAN'S NAME (Type): J. R. GARCIA-VELEZ

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/27/59

22c. NAME OF CEMETERY OR CREMATORY: Philo's

22d. LOCATION (City, town, or county) (State): Westernport, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: E.S. Boal

ADDRESS: Boal's Funeral Home, Westernport, Maryland

24a. REC'D BY REGISTRAR DATE: JUL 27 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7863 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07848

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, R.D.
c. LENGTH OF STAY IN 1b: 4 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Meadowview
d. STREET ADDRESS: 5 Walnut Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Austin; Middle: Jacob; Last: Ward 3rd

4. DATE OF DEATH: Month: 7; Day: 13; Year: 19 59

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-4-1959

9. AGE (In years last birthday): ——— yrs. IF UNDER 1 YEAR: Months: 4; Days: 9; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wilmington, Del.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Austin Jacob Ward, 2

14. MOTHER'S MAIDEN NAME: Shirley E.N.Hallitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: ———

17. INFORMANT Address: Jacob Austin Ward 2nd Meadowview Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Smothered — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

9240

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Was covered with bed clothes in sleep

20c. TIME OF INJURY: Hour 3 a. m. p. m. — Month, Day, Year: 7 13 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Elkton, R.D. Cecil Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C.Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 7-13-59

EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: JULY 16, 1959

22c. NAME OF CEMETERY OR CREMATORY: DAMASCUS CEMETERY

22d. LOCATION (City, town, or county) (State): HANCOCK, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Donald M. Lee ADDRESS: PIPPIN FUNERAL HOME ELKTON, Md

24a. REC'D BY REGISTRAR DATE: JUL 15 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kinna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7864

CERTIFICATE OF DEATH

07849
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City
c. LENGTH OF STAY IN 1b: 53 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chesapeake City
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAUL — Middle — Last WASYLCZUK

4. DATE OF DEATH: Month July — Day 5, — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 12, 1888

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10b. KIND OF BUSINESS OR INDUSTRY: Baking

11. BIRTHPLACE (State or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Wasylczuk

14. MOTHER'S MAIDEN NAME: Mary 666----------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 221-03-9300

17. INFORMANT: Mrs. Lena Wasylczuk, Address: Chesapeake City, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Metastasis To Lung — INTERVAL BETWEEN ONSET AND DEATH: 6 Months
DUE TO (b): Carcinoma of Prostate — 5 years.
DUE TO (c):

177x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 19 59, to July 5, 19 59, that I last saw the deceased alive on July 4, 19 59, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry V Davis M.D. — ADDRESS (Street, city or town, state): Chesapeake City Md — DATE SIGNED: 7/9/59

PHYSICIAN'S NAME (Type): HENRY V. DAVIS MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 9, 1959

22c. NAME OF CEMETERY OR CREMATORY: St. Roses Cem.

22d. LOCATION (City, town, or county) (State): Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME — ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: JUL 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS